Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Aging and Independent Living &
Department for Behavioral Health, Developmental and Intellectual Disabilities

PARTICIPANT DIRECTED SERVICES
EMPLOYEE TRAINING VERIFICATION

As a chosen employee, I certify that I have completed the following topics, which exceed what is required by the College of Direct Supports, required by my case management agency, DAIL, BHDID or employer:

_____ _____
Date

_____ _____
Date

_____ _____
Date

_____ _____
Date

_____ _____
Employee Signature **Date**

_____ _____
Consumer/Representative/Employer Signature **Date**

_____ _____
Case Manager Signature (if applicable) **Date**